MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
SPECIAL CERTIFICATE OF NEED (CON) COMMISSION MEETING

TUESDAY, OCTOBER 7, 2003

Holiday Inn West Conference Center
Regency Ballroom C/D
Lansing, Michigan

APPROVED TRANSCRIPT (MINUTES)

Members Present:
Renee Turner-Bailey, Chairperson
Jack Smant, Vice Chairperson
Peter Ajluni, D.O.
Richard Breon
Bradley Cory
James K. Delaney
Edward B. Goldman (arrived 9:15am)
Norma Hagenow
Michael Sandler, M.D.
Michael Young, D.O.

Members Absent:
James Maitland

Department of Attorney General Staff Present:
Ronald J. Styka

Michigan Department of Community Health Staff Present:
William J. Hart, Jr.
Larry Horvath
Brenda Rogers
Jan Christensen
Stanley Nash

General Public Attendance:

Approximately 53 people in attendance

Commencing at or about 9:03am.

MS. TURNER-BAILEY: Good morning. I would like to call this special meeting of the Certificate of Need Commission to order. It's 9:03 according to my timer here. At this time I would like to ask everyone to take a quick review of the agenda. If there are any suggestions for additions, changes, deletions, I will take a motion to that effect now.

MR. SMANT: Support.

MS. TURNER-BAILEY: It has been moved by Commissioner Delaney, supported by Commissioner Smant to accept the agenda as written. All those in favor signify by saying aye. Opposed? Motion carries. Agenda item 3. Declarations of conflicts of interest.

As you may recall from our last meeting, we did have a couple of specific questions relative to conflicts of interest. Several action items came out of that meeting, the first of which was the Commission did vote and agreed that I would, on behalf of the Commission, request an opinion of the State Ethics Board as to conflicts of interest in this particular case that we are dealing with today, which is the proposed hospital bed standards. And at the same

time, as an aside, we requested an opinion relative to voting on the lithotripsy standard, which is not on the agenda today.

We have not received a response to that inquiry yet and I think what we learned at the last meeting was that it does take a bit of time to get a response from the State Ethics Board. So, unfortunately, we don't have that guidance to help us with our actions today.

However, we do have a written opinion from Ron Styka, who is our legal counsel, our official legal counsel. And, Ron, if you don't mind, I would like to ask you if you would summarize for us your thoughts on this matter.

MR. STYKA: Okay. I didn't know you were going to ask me that. I've given you a memorandum that actually reads very similar to a memorandum that was given to the Commission a couple years ago dealing with ad hoc committee membership. And basically the memorandum indicates, first, that you do have procedures in your bylaws dealing with conflicts of interest. You have a definition of conflict of interest in the bylaws, and the bylaws make it the proper procedure for this Commission to consider an issue of conflict of interest, discuss it, take a vote on it, if such an issue does arise.

Second, you mentioned the ethics board. Since you have asked formally for their opinion, it really wouldn't be proper for me to give you an ultimate opinion as to whether I think it is or is not a conflict of interest. I'm not sure it would be anyway because of the way your bylaws are written. But clearly that has been sent over to the ethics board by this group.

Now, I did talk with the attorney who represents the ethics board as recently as yesterday. She is working on this but indicates the ethics board matters usually take months before you get an answer. So you won't see anything -- I'm not sure you will see it by your December meeting, quite frankly, although you might. She still has questions concerning facts, background which I have been trying to help her with, send her to the right places. So it's being actively worked on, but it's going to be a while before they do it.

So having that in mind, having talked to you about the issue, Madam Chairperson, and I put together this memorandum that just generally talks about the conflict question, mentioning the fact that under the new law we now have a Commission that is made up with people of special interests. We have a Commission that has representatives of hospitals and different medical practice modalities and nursing homes and other groups. So that the legislature had in mind that the people on this Commission would have expertise or experience in areas. But that also means that very, very often throughout the life of this Commission, going forward, not just on today's issues, there is going to be the appearance, at least, of maybe some conflicts which will have to be addressed by this Commission as you go along.

Then I started looking at the statute that the ethics board does deal with that you are subject to, and really the question of what's a direct conflict becomes the key element. That's based on court decisions and the statutory language. And the issue of conflict of interest has been dealt with primarily in the courts and even by the ethics board with there having been some sort of a direct line connection to a pecuniary interest. And so then I summarized on the last page of my advice, as I did with regard to ad hoc committees a couple years ago, that to my way of thinking, and again this is your decision you have to make based on your bylaws, but as a guidepost I indicated that clearly, and, of course, there are many unclear areas, but clearly in a situation where an individual has an ownership interest in a directly affected health facility or modality, such as a service or whatever, they would have a conflict of interest. Clearly individuals who exercise a degree of control, such as a member of a governing board or CEO, that sort of thing, over a directly affected health facility or modality would have a conflict.

Individuals whose compensation is determined by a formula related to the outcome of the Commission's deliberations undoubtedly would be in a conflict. And individuals who, because of the method of their compensation, can influence the amount of that compensation to the content of the review standard or action that is under review would be a conflict. Those are ones that I think are clear. After that you have to start using those thoughts and the general principles of what's direct, is it pecuniary, does it relate to this person's pocketbook, essentially, to apply these yourself to the more gray areas.

MS. TURNER-BAILEY: Thank you. Are there any questions? Any questions? Are you going to speak?

DR. SANDLER: Yes.

MS. TURNER-BAILEY: Okay, Dr. Sandler.

DR. SANDLER: The only thing I wish to say is to say what I have said at previous meetings, that there is something on the agenda that somebody could say is a conflict of interest if one is employed in a position at Henry Ford Health System, and my response is that there is no conflict of interest because I am paid, 100 percent of my salary is paid to read radiographs, or in my case, ultrasound. I will not get a penny one way or the other regardless of the deliberations or any decision which is made by this Commission in terms of any standard. And I, therefore, would have nothing to gain in a personal sense.

In addition to that, virtually everything not on this agenda but on the last agenda, virtually every single item would have some effect on every health care facility in the State of Michigan, although most certainly CT, MRI, radiation therapy and lithotripsy will affect (inaudible), Genesys and Spectrum. So, therefore, I do not feel that I have any more conflict of interest than the majority of the commissioners.

MS. TURNER-BAILEY: Any other questions? Comments? I was going to ask for declarations, but I think that is your declaration. That you don't have a conflict, not that you do have.

DR. SANDLER: The declaration is that if someone may wish to bring this up, and I say I could understand someone saying, well, does he have a conflict of interest, I'm saying I can understand someone feeling a potential, but I don't think anything is there

And regardless of how the ethics committee were to give a decision, that decision is not binding. It is within our guidelines that this Commission decides the declaration of interest. Perhaps some guidance from them.

MR. STYKA: Yes, they are advisory opinions. Ultimately, your bylaw procedure, you will have to decide even after you get the ruling.

DR. SANDLER: I think the key point is that on virtually every item you couldn't have physicians and hospital administrators on this Commission, and certainly the intent of the legislature was that we had an expertise to offer. And then we are supposed to reach a consensus with the other members.

MS. TURNER-BAILEY: Yes, Commissioner Hagenow?

MS. HAGENOW: Since I was the other individual named. I think that the opinion still leaves the point around direct. Yes, I am a part of Ascension Health nationally. But in this state the question becomes is this a direct line for me to receive any economic return as a result of deliberations and the decision one way or the other. And my contention is that I do not have a direct conflict of interest because Ascension Health -- I mean Genesys, reports to my own local board and we are tied together as a network nationally, but there is no exchange of money for me from the Providence, St. Johns System or the Ford System. So I think the key word for me is direct. But I guess since it has been put on the table, I feel a need to respond. That is the key issue, I think, and is for the rest of the group to decide whether it is direct or not.

MS. TURNER-BAILEY: Any other questions relative to or opinions relative to this issue? Okay, hearing none, we do expect a response from the ethics board at some point. That's not, as I said, available to us today. We have heard the comments of two of our Commissioners, and, as mentioned, these are issues that I think we will continue to deal with. But certainly I, for one, appreciate Ron's advice and also look forward to the advice of the ethics board as we move forward to deliberations on various issues. Okay, I want to go to agenda item 4, review of the minutes of the September 9th meeting. If you have had an opportunity to look over those minutes, I at this time ask if there are any additions, corrections, changes. It's kind of difficult when it's a transcript, but.

MR. DELANEY: I move to accept the minutes as written.

MS. TURNER-BAILEY: It has been moved by Commissioner Delaney that the minutes be accepted as submitted.

DR. BREON: Support.

MS. TURNER-BAILEY: Supported by Commissioner Breon. All those in favor signify by saying aye. Opposed? Okay, motion carries. Agenda item 5 for proposed hospital bed standards, which is the main issue that we are brought here to deal with today.

You may notice a slight change in the order of how we have our agenda item. We are taking public comment first. A couple of comments: One, that the first is that we are doing that so that we can sort of give the Commissioners the benefit of all comment prior to going on to our discussion. And secondly, to, in some way, if possible, contain that public comment. So the public comment period is going to be the only time we take public comment on this issue unless it's at the end of the agenda. So I urge you, if you want to submit a card, please do so before we get to the end of this agenda item.

Secondly, we have asked that you limit your testimony to five minutes. That's in recognition of the fact that, honestly, we have heard many, many opinions on this issue so far in the various meetings we have had over the last six months and to give everyone who wants to speak an opportunity to speak during our time frame. Finally, if you do have written testimony that you would like to submit, we ask you to do that. We are happy to take that.

Okay, so I'm going to start going through the cards. Oh, the other thing is we are going to take a short break at 10:30. That's to accommodate our court reporter but also, I suspect, to accommodate all of us at that point in time. Okay, our first speaker is Teresa Lewis, City of Detroit.

MS. LEWIS: Good morning. I did not expect to be first, but I thank you so much for allowing me this time.

My name is Theresa Lewis, and I am the President of the City of Detroit 11th Precinct Police Community Relations Council. And I stand before you this morning at the request of our community, which serves the northeast, the St. John Northeast Hospital. We would like to request that the consideration of moving beds not be considered. Our community is a very large voting community. We are an older community and the needs of the community are for a full-service hospital.

We do not feel as though we were involved in any decision-making in the process to move the beds nor were we aware of a process that was to be followed. And in light of the fact that you do have a five-minute limit, and I am going to be very, very cognizant of that, I do want to make sure that you understand that by no means are we saying that, you know, we are angry at anyone, we just want the committee to understand the needs of this community.

The community visits the hospital quite often, and a lot of people have no other means, no other way to get anywhere else. We don't have any transportation services to the other hospitals. So we are asking that you consider leaving the beds in Northeast, determine how we use the hospital, please consider that we do serve a large community of homeowners, people who are getting older and need those services.

And I want to thank you so much for your time, and I'm going to say that I'm tired; meaning, because I do not understand the whole process, but I do want to understand it when I share this information with the community.

DR. SANDLER: I have a question.

MS. TURNER-BAILEY: I'll ask.

DR. SANDLER: Sorry. Go ahead. I thought that she was starting to walk away. Thank you for your testimony. I'm confused about one point. I believe, and please correct me if I am wrong, the gist of your concern refers to St. John Northeast Hospital only, not Holy Cross?

MS. LEWIS: Yes. That's the gist of my concern.

DR. SANDLER: I understand that concern. I'm old enough to remember that as a vibrant Holy Cross Hospital. However, I don't believe the St. Johns people can speak to this, whether they choose to close Holy Cross -- excuse me, St. Johns Northeast or not is not related to this, whether this standard passes or not, however.

MS. LEWIS: Well, I think that is my whole question. If the beds are not moved from that hospital, does that say that the hospital cannot fill the beds or can fill the beds?

DR. SANDLER: Well, I think that's something you have to take up with the St. Johns Healthcare System.

MS. LEWIS: Okay.

DR. SANDLER: And I would advise you to do that. There are physicians, I'm not going to cause any trouble for my friends in St. Johns, there are physicians at St. Johns who took out newspaper ads from St. Johns Northeast who feel that way.

MS. LEWIS: Yes.

DR. SANDLER: And you probably know those physicians.

MS. LEWIS: Yes.

DR. SANDLER: But I don't believe that that's necessarily related to the standards that we are looking at. In other words, the standards pass, they may close; the standards don't pass, they may close anyway.

MS. LEWIS: Right. I understand that. My question is, is moving the beds a part of that decision, or does moving the beds come before the community just because it eliminates bed space in the hospital?

DR. SANDLER: I understand your concern, and perhaps the St. Johns people, when it is their time, can comment on it. There are St. Johns corporate people here.

MS. LEWIS: Thank you very much.

MS. TURNER-BAILEY: Thank you. Are there any other questions? Thank you.

MS. LEWIS: Thank you.

MS. TURNER-BAILEY: Martha Scott?

MS. SCOTT: Good morning. Thank you for allowing me the opportunity to testify. I am State Senator Martha G. Scott, District 2, which includes where St. Johns is located, and I am here representing the people of my district. As Mrs. Lewis is one of those people in the district.

We voted last year to allow 200 beds to be moved. And I asked St. Johns at that time, would this have anything to do with the quality of St. Johns, with the closing or anything. No, this was not going to have anything to do. I just think that there is an integrity of standards that we have, and I am really concerned about this.
There are beds that were vacant, but the beds are vacant in the city of Detroit because the hospitals are not kept up to standards as they are in the suburban areas. We have lost a number of hospitals in Detroit. We have a number of schools in that area, churches, and if anything should happen to those people, they are a distance away from any emergency service. And I am truly concerned about that.

We have lost too many hospitals. And it's only because they say, well, you know, they are vacant, people are not here. They are not there because they go further so that they can get better service. But it is not fair to the families of this community for them to have to go that distance to get service. So I am here really concerned about that.

And I just think that because I was told that there would not be any interruption in service, I don't think it's fair. So I'm here to ask you to have some sympathy, some understanding for the city of Detroit and its people that live in the city of Detroit. They should not have to go the distance that you are requiring them to go now.

MS. TURNER-BAILEY: Thank you. Are there any questions? Thank you.

MS. SCOTT: Thank you.

MS. TURNER-BAILEY: Dale Steiger? I'm sorry, I didn't know if you wanted to speak during this portion.

MR. STEIGER: Good morning. My name is Dale Steiger. I'm with Blue Cross Blue Shield of Michigan. But more importantly at this juncture, I'm the chairman of the Technical Advisory Committee of the Bed Need Ad Hoc Committee.

The objectives of this Technical Advisory Committee, as I have indicated in the last several meetings, are to review and revise two methodologies and determine the number of beds that are needed in the State of Michigan and the location of those beds.

We will be defining, redefining sub-areas and we will be defining the bed need methodology and making fairly substantial changes to both of those methodologies.

I indicated at the last meeting in September that our group has been working quite diligently. We have a meeting scheduled again for tomorrow. And it is certainly our intent, and I wanted to make sure the committee is aware of this, the Commission is aware of this, it is certainly our intent to have our finished work product to the Bed Need Ad Hoc Committee and then back to the Commission in advance of their December meeting. So that's basically my message this morning. I would be happy to entertain any questions.

MS. TURNER-BAILEY: Are there any questions? Thank you. Vin Sahney?

MR. SAHNEY: Good morning. My name is Vin Sahney, and I am Senior Vice-president of Henry Ford Health System. I would like to thank the Commission for scheduling this special meeting to discuss the proposed revisions to the hospital bed review standards.

I'm going to be quite brief, as Madam Chairman asked for that. I'm going to make three key points and just go over that in a little bit of detail to make our case.

I'm speaking this morning in support of the proposed review standards for hospital beds. My first point is that these standards take into account the current reality that large ambulatory care centers in many cases are just as sophisticated and technically advanced as a 2- or 300 bed hospital. And I have in the previous testimonies mentioned in detail what our West Bloomfield center entails and all of the technology that it has.

Permitting a health system to move beds from a licensed hospital to one of these full-service, 24-hour ambulatory care centers is also consistent with the hospital-to-hospital bed transfer that you approved earlier this year. You allowed, according to your own methodology, that the hospital should be able to move beds from one hospital to another. So my key point is that one of our centers here is as sophisticated as a 2- to 300 bed hospital.
By now you have heard most of the arguments for and against approving revision to the standards for hospital beds at least once and sometimes many times over. Dialogue over this topic has continued to develop for close to one year, maybe over one year. As the dialogue has continued, the precarious situation in Detroit continues to worsen. And my reason for mentioning this is that even your own brochure here that was put on the table said that one of your responsibilities is to look at access. Access to care.

As a result, the Detroit health systems need this relief even more than they did a year ago when we went to the legislature. My key point to the legislature was that unless some help comes from Lansing, the Detroit health systems one by one will crumble, and the domino effect will be there and one by one the hospitals will close. And if you remember earlier I had testified that over 20 hospitals have closed in the last 15 years in the city of Detroit.

If you follow news reports, you know that the critical financial balance at the Detroit Medical Center is also at a crisis stage. The Detroit Medical Center is a renowned institution that is the training place, along with the other Detroit-based institutions, for a large percentage of the physicians and other healthcare professionals in this state. But with its large burden of indigent care, DMC exemplifies the point that no healthcare institution can thrive, or perhaps even survive, when more than half of its patients are uninsured or underinsured. The situation that exists

at Detroit Medical Center is an indicator of what could happen across the city, and this applies to Henry Ford Health System.

For the last five years on our Detroit campus we have been incurring large operating losses only balanced by our suburban facilities. Detroit stabilization team continues to work toward establishment of a health authority for the city, and we have been an active part working with the Governor, working with all the other hospitals to try to create this health authority, but it is apparent that the multifaceted solution to the challenges of the Detroit-based providers is necessary. That stabilization itself won' t work all the way.And if you have seen the Medicaid budget projection for next year, they are in trouble again.

Allowing Detroit-based health systems to participate in the growing Oakland County market represents a market-based approach to this problem. And this is the case we made to the legislature. As we have noted in the past, the western side of Oakland County, home to over half a million persons and growing every year, has only one hospital. So if you divide Oakland County in half, you get about half the people with only one hospital. In 2002 over 250,000 hospital patient days were generated by residents in western Oakland County. At 80 percent occupancy, this will mean that we will require 871 hospital beds to take care of these people. Currently there are only 153 beds in western Oakland County. And since the sub-area is an arbitrary designation that was created sometime back, my point here is that even from access to Oakland County patients there is a need for hospital beds in that area.

Obviously these patients are traveling elsewhere for their care. But as the population increases, the traffic routes become even more congested, this will become even a less acceptable solution. Permitting the Detroit hospital systems to introduce a full continuum of care in the existing facilities will support safe patient care and make good use of existing healthcare resource.

We have 160 acres at the West Bloomfield site that we acquired back in 1975 with the full intention of building a hospital. A 24-hour emergency room, six operating rooms, MRI, CT scan and radiation therapy, all of that exists in this location.

Finally I want to reassure those with concerns that allowing the proposed redistribution of resources will negatively impact the core population of patients that we serve in Detroit. Just the opposite is true. Henry Ford Hospital in Detroit is our flagship hospital and will continue to be so. It is the core of our medical education, research and tertiary care programs. Allowing us to have access to a more favorable payer mix will support our mission of excellence at every site that we provide care.

And just to reassure the previous two speakers, in the last three years we have invested $80 million in our West Annex facility on a replacement project for 100 beds. We are right now in the planning stages of expanding our emergency room and building -- just one more minute.

Now just so that you have a concern, I have a letter from the Mayor of Detroit supporting this thing. So I would pass that letter on in a minute and give it to you.

So we anticipate expanding our facilities in Detroit and then serving the community as the need might be, but economic alliance projections are there are 1,600 too many beds in the city of Detroit. So moving 300 beds from there is not going to reduce the access to the city.

So in closing I just want to emphasize three points. The major ambulatory care centers that will be candidates for hospital beds are already sophisticated medical, diagnostic and surgical centers. This is a hospital without beds. There is an access issue in western Oakland County that you need to look at. And access to care in Detroit will be strengthened if you allow this thing to go forward.

The Public Health Code states that one purpose of the CON process is to ensure access to care. And your brochure, as I mentioned, says that. Your approval today will assure continued access to health care services for the citizens of Detroit and will improve access to care for Henry Ford patients who live in western Oakland County.

Thank you for listening to this. I have for the members of the board from Mayor Kwame Kilpatrick, which I will pass out here. I also, to save time, have letter of support on access from the trustee from West Bloomfield Township and the West Bloomfield Township clerk. So to address the issues of access in that county also.

MS. TURNER-BAILEY: Thank you. Are there any questions? Mr. Goldman?

MR. GOLDMAN: So your representation to this Commission is that for the foreseeable future there will be a substantial presence in the city of Detroit; in fact, an expanded emergency room presence in the city of Detroit to service the citizens of the city of Detroit; is that correct?

MR. SAHNEY: Yes. And we are already putting things in place to expand the downtown emergency room, you know, which was built and we have over 100,000 visits there. To give you an idea, our Detroit campus has a revenue of over $750 million. I mean, in just one location. And we are not going to abandon that or close that. There is no way we can survive that and carry the overhead cost. So that one we are expanding and planning to expand. As I just mentioned, we just renovated some 100 beds.

MR. GOLDMAN: And you are going to go forward with your emergency room expansion?

MR. SAHNEY: Yes, sir.

MR. GOLDMAN: Thank you.

MS. TURNER-BAILEY: I have a question. Is it your thought that an objective evaluation of bed needs within Oakland County relative to the population will demonstrate that there is a need for additional beds?

MR. SAHNEY: I think it is just like political redistricting. You have to decide how you draw the boundaries of the line. If you divide the Oakland County exactly in half, western Oakland County and eastern Oakland County, the population of 700,000 in each, 1.4 million overall, it will show that the western Oakland County underbeded. Only one hospital.

The (inaudible) hospital is on the eastern side. But the original old Oakland County there is one hospital on the western. So that is the dividing line. So the answer is, if you combine it all into one service area, that would be like my adding all of Detroit into one service area and saying there are too many beds. Yes, in all of Detroit County. So I think it is a question of how you divide the sub-areas.

MS. TURNER-BAILEY: Any other questions? Dr. Young?

DR. YOUNG: So in your opinion you think there is room for two hospitals?

MR. SAHNEY: I gave you the statistics right now. You can apply the bed need methodology to the population and multiply it out and it comes to 851 beds, according to current, with only 150 beds. So we are only asking for 500 beds. That still would be....

MS. TURNER-BAILEY: Any other questions? Thank you.

MR. SAHNEY: Thank you.

MS. TURNER-BAILEY: Patrick O' Donovan?

MR. O' DONOVAN: Good morning. My name is Patrick O' Donovan, Director of Planning for Beaumont Hospitals. Thank you for the opportunity to provide comment this morning on the proposed CON standards for hospital beds.

We believe these proposed standards are not in the best interest of Michigan residents and we urge you to reject them on that basis.

The Certificate of Need statute, PA 619, requires that the Commission develop CON review standards that establish the need, if any, for health services and facilities that are covered under the CON program. The

proposed revisions to the standards do not contain any element of need whatsoever, they simply award new hospitals without any consideration of the impact of those hospitals on the cost, quality or access to healthcare services in the state.

The department is pushing hard to get these standards approved by the Commission as part of a political agenda. But it is the Commission that decides what changes should be made to CON standards. And the Commission has historically gone to great pains to make sure they got it right, even if it took some time to do so.

When policies are made without getting it right, there are often unintended consequences, as there could be if these standards are approved. Consider the following: In their written comments on the proposed standards the department states that, quote, "The intent is to allow a limited number of transfers of hospital beds from urban systems of hospitals to recognize the importance of payer mix to the survivability of urban hospitals." If that is to be state CON policy, then shouldn't the same new hospital need exemptions apply to hospitals in other urban locations in the state such as Pontiac, Flint, Lansing, and Grand Rapids?

The proposed standards allow up to 900 beds to be transferred out of Detroit to the suburbs, and further require that half of the beds transferred from Detroit be staffed beds. Since hospitals cannot afford to, and hence do not, staff empty beds, this means that up to 450 patients a day who are currently in hospital beds would no longer have access to those beds. Where will those patients go? And can the city of Detroit afford to lose more jobs to the suburbs? If not the CON Commission, who is planning for beds in the city of Detroit?

The building of unneeded hospitals will have a negative effect on the competitiveness of Michigan in the national and world economy. Data from GM, Ford and Daimler/Chrysler all show that their health care costs are lower in CON states than in non CON states. How does building new hospitals that may not be needed fit in with the Governor's desire to keep or add manufacturing jobs in Michigan? Proponents of new hospitals cite population growth in western Oakland County as justification for new hospitals. What about other areas of the state experiencing even higher rates of growth, including Livingston County, northern Macomb County, Antrim County, Benzie County, to name just a few. Should these growing areas be awarded hospitals without having to show need?

If new hospitals are awarded without thoughtful planning, even once, this will lead to the end of any credible CON program in Michigan, resulting in a proliferation of new healthcare facilities and equipment, many of which would be for-profit enterprises that would diminish the ability of nonprofit hospitals to serve their communities. This is already starting to happen. At least two Michigan hospitals have hired lobbyist to assist them in establishing new standalone hospitals.

The Medicaid program should adequately reimburse hospitals for the cost of caring for those patients. Medicaid underfunding is a long-standing statewide issue that must be addressed by the state legislature. But accepting the pretext that new hospitals can compensate for government underfunding will lead to further underfunding and more new hospitals in growing areas. New hospital construction without demonstrated need is the wrong way to address hospitals' financial shortfalls. And as we previously demonstrated, based on the experience of our Troy hospital, the new hospitals will not realize the profits their sponsors claim.

We seem to be at a crossroads. Either we are going to have a strong, credible CON program in this state, as we have now, or we are going to let it wither away. We hope that you will conclude as we do that a meaningful CON program is in the best interests of Michigan residents.

New hospitals should be authorized only after a rational, data-driven analysis showed the need for such hospital. Since these proposed standard were not developed based on need criteria, they should be rejected. Thank you.

MS. TURNER-BAILEY: Thank you. Are there any questions? Thank you. Larry Horwitz?

MR. HORWITZ: I'm Larry Horwitz. I'm president of the Economic Alliance.

As someone has said, you've been through this before. This is the most extended consideration of a CON issue that this Commission has ever considered in its 14-year history. I think that's reasonable, though. Because what you are being asked to do is something very different than you have ever been asked to do before. What you are

being asked to do is to create an exception -- this is called the Certificate of Need program. You are being asked to make an exception to the need program without any demonstration of the justification of it based on need. Your obligation is to identify need in the area to be served, and that's not part of this.

This is done based on a proposal to help the problem of the state's, the problem of not having adequate funds from federal and state sources and others for indigent care in the city of Detroit. So we are using CON to solve a Medicaid problem. We are using CON to solve an uninsured program. I submit to you that's in denigration of the responsibility of this Commission in terms of its responsibility to the rest of state; and two, it really won't solve the problem anyhow.

I do want to emphasize, though, because this is inherent in all of this so many times, let me just share with you what new information we have to bring you. Ours is a business labor organization. We are concerned about healthcare costs and the viability of access for our employees, our retirees, and the viability of jobs. As you know, this is the first time in American history we have had an economic recovery in which jobs have gone down. A key element of that that people point to is the continuing rise of healthcare costs. There are many other factors, but that is certainly one of them. The Governor is calling a summit to deal with that. We submit that you authorizing two new hospitals, focusing now on the FSOF conversion, is something that is going to net increased costs.

We have asked the Blue Cross people to give us an estimate of what it would cost on net for adding two new 300-bed hospitals. Because the standard before you is to allow each of them to build 300-bed hospitals. I don't know where the 500 comes from, 300 beds each is the document now before you. The Blue's estimate on the Blue's piece of paper is that in general for a hospital it would be a net increase of $500 million. Gross increase of 600 million offset by what their estimate is, 10 to 15 percent cost savings from having people no longer at some other place now coming to this hospital. But most costs at a hospital are fixed costs, according to the Blues.
The Providence application is the only one before the department. It says it could cost them 180 -- $120 million for a 200-bed hospital. I presume that that, you can extrapolate that up to 15 percent, that's 180 million. The Blues estimate is 300. Why the difference? I think the difference is the Blues were estimating hospitals in general, including there is a lot of infrastructure already in the ground at both Providence and Henry Ford. There is a basement, there is infrastructure, there are facilities.

Let's take the Providence number for this unique situation, so it's going to cost $260 million. I'm assuming since Ford hasn't submitted anything, I'm just extrapolating for them to be the same, 260 minus the 15 percent offset is $300 million. $300 million is nothing to sneeze at. When you made changes before for anyone else you allowed hospitals to -- Beaumont got extra beds. When they already were proven and established to have 85 percent plus occupancy. Here we are making an assumption that they are going to get to 85 percent occupancy.

Providence's application, I have it in any hand, has the most amazing projection that they will in their third 12 months of operation be at 85 percent occupancy. An occupancy level only four hospitals in the state of Michigan have exceeded at this point. They will get a 9 percent profit margin. The average profit margin in this state is 2 percent. These are phenomenally and unfathomable numbers to believe.

Who is hurt by this? What we think is hurt by this is the business community. I have submitted to you, to give you an extra copy of a document you got last time from the Michigan Chamber of Commerce and the Michigan Manufactures Association, signed by their leadership, who urged you back in September not to adopt this standard because they felt it was bad for the business and jobs climate. A rather different organization than the Economic Alliance. They have no union members. In fact, the Chamber of Commerce spent a lot time fighting with our union members on various other questions these last two weeks in the legislature. But we all agree that this is not a good idea.

Who else is hurt? The Detroit Medical Center is going to be significantly hurt. Their institution in the city of Detroit is at the greatest stress from the problems of indigent care. Why are they going to be hurt? Well, they are not going to be building any new hospital anywhere; they don't have two pennies to rub together to build a new hospital someplace. The theoretical allowance for them to move beds and add it to someplace or other is rather illusory. What we do know will happen is their Huron Valley Hospital is going to be seriously hurt and go back into deficit.

We would urge you, therefore, to say CON is not the solution here. What is the solution here is for the state to be dealing with the problem of primary healthcare clinics, assist getting state and federal money in there, as in the articles in the Free Press last week.

What' s causing hospital patients to leave the city is because their doctors are leaving the city. Their doctors are leaving the city because of the indigent care and Medicaid problem. If you now have the hospitals move more of their activities out there, then that is going to cause a further sucking of patients out to the suburbs, leaving less jobs and less access inside the city of Detroit.

What do we ask you to do? In two days there is a court hearing. If you pass this standard now you are subverting the judicial process, which I think is rather unseemly for this Commission to do. The bed need question that you want to deal with this is coming forth to you at your next meeting. We would urge you not to vote for this, and not to accept the premise that four hospitals in Oakland County, which are in the middle, are neither east or west, the fact of the matter is two new hospitals in western Oakland County are going to just suck patients from hospitals that already exist. It' s a zero net gain. Thank you.

MS. TURNER-BAILEY: Any questions? Hold on, please.

MR. HORWITZ: Surely.

DR. SANDLER: I have one brief question slightly off the topic I did before and FYI. Where are the four hospitals that have the 85 percent? You named Beaumont.

MR. HORWITZ: Say again, please?

DR. SANDLER: What are the four hospitals that have the 85 percent occupancy? You said there were four hospitals. I know Beaumont. Really just for my own knowledge. University of Michigan?

MR. HORWITZ: Let me just make sure. The ones that I know of are three for sure, Genesys in Flint, Beaumont - Royal Oak, and Beaumont - Troy are the three that I know of for sure. I have heard of others alleged, so I misspoke myself by saying four. Those are the three that have submitted data to the department saying that they are at that level. So far U of M has not submitted data to indicate that.

DR. SANDLER: Thank you.

MS. TURNER-BAILEY: Are there any other questions?

MR. GOLDMAN: Yes, I have one.

MS. TURNER-BAILEY: Commissioner Goldman? Wait until we finish with the questions.

MR. HORWITZ: Yes, ma' am. Sorry.

DR. SANDLER: I know you are reluctant to stand up here and talk.

MR. HORWITZ: I' m trying to be responsive to the Chair.

MR. GOLDMAN: Say it were to come about what we could do at our next meeting once we have the bed need methodology numbers and the changes that may come from the bed need committee, how will that tie to this process?

MR. HORWITZ: Then you would be able to look at whether or not there is a standardized basis for your assessing need for building new hospitals. And that is your statutory obligation. That' s what it says in the statute. You are not supposed to decide based on miscellaneous stuff, you are supposed to have some comprehensive, rational basis under 14th Amendment and other criteria to do that. And that' s exactly what the revision of the bed need standards are doing, and deciding whether these sub-areas and to what extent the sub-area configuration should be modified.

MR. GOLDMAN: So that if Dr. Sahney is correct that there is underbedding, at least in part of Oakland County, your expectation would be that that would come out in the bed need methodology and we would then have some harder facts to look at in making the allocation?

MR. HORWITZ: Yes. And you would not be subject to saying you only looked in Detroit and didn't bother to look anywhere else. You didn't look in this area and that area. You would not be subject to saying you acted in an inconsistent --

MR. GOLDMAN: So that would answer the Beaumont question about Atrium, Benzie, northern Macomb and those other areas as well.

MR. HORWITZ: Atrium?

MR. GOLDMAN: Antrim, sorry. Antrim County. Atrium was a battle in the civil war.

MR. HORWITZ: That's Antietam, Mr. Goldman. The question is, is that true? The data we have looked at does not demonstrate there is a need for beds in western Oakland County. We have our office there, and in the two hospitals that are within a ten-mile radius of those two sites there is a 48 percent occupancy. So we don't see it.

MR. GOLDMAN: I think that's the point, there have been allegations both by Beaumont and by Henry Ford about need in various portions of the state of Michigan. Your argument, I take it, is if those arguments are true, we should have a methodology to look at it. We should have a comprehensive methodology, and we should go on the facts that come out of that methodology.

MR. HORWITZ: Right. You shouldn't be relying just on our data which shows there isn't need and their data which shows there is, there should be some standardized method for doing that. Otherwise, you don't have a CON system. Otherwise, you now as a Commission are sort of ad hoc in making decisions.

MS. TURNER-BAILEY: Commissioner Hagenow.

MS. HAGENOW: Maybe you can enlighten me. I'm struggling with the common good when there is a difference in the economic climate that makes a difference in what the need is. If you take a number just based on population and don't consider the economic environment, I think that places where Genesys is or the western counties, there is a different economic climate where competition and market work. And they tend to change what utilization is. When you get to downtown Flint or you get to downtown Detroit, it seems to be the common good becomes a public good which has to be both financially sustained in a different way and it drives a different kind of demand.

So I see in the one place where the economic environment drives competition, which may be the most efficient, and in another environment competition just doesn't work because nobody wants to compete there. So it has to be a different driver. And I'm not sure that your theory of setting the beds based on the population at an equal level works. And that's what I'm struggling with. And just your enlightenment on that.

MR. HORWITZ: Well, if you were to say you want to vary bed need according to economic status, then you -- which is a judgment this Commission may make, which so far we have never done -- if you did that, then you would need extra beds in Detroit and central Flint. Because what we do know is that health status of people are worse off in lower economic areas and better off in higher income areas. And if that were to be followed, then you would say you would need somewhat more beds than your statewide formula in Detroit and Flint, and somewhat less beds in southern Flint and western Oakland.

MS. HAGENOW: But I don't necessarily see that, because what the need is in the inner-city is for public health that makes a big change in status, whereas the in-health status. So a public health change could make a significant difference in the utilization. So again I still come back to that I don't think a number based on population sets the need.

MR. HORWITZ: Well, the formula always has been population and age, which is widely variant, and third, what the new advisory committee is doing is trying to factor in actual use patterns. Instead of trying to make everybody be less than the statewide norms. So they are allowing the bed need formula to float, such that in those areas where there is greater utilization there will be more beds. Which I think taps into something what you are saying.

MS. HAGENOW: Yeah. I don't necessarily have a conclusion, I just am trying to explore the fact that using the population-based numbers and the traditional formula, there is this many people and there is this age, is truly the American system. I think that there is a difference in the economic climate that drives -- and competition may be the most effective in an environment where there is economic worth in that community, and in another the solution is a public health solution rather than a bed need solution.

MR. HORWITZ: Well, to some extent the advisory committee, technical group, is already dealing with that by taking off that norm and allowing higher -- for example, the Flint Genesee County has a much higher utilization of healthcare resources than almost any other significant county in the state as a medical practice, lifestyles. And that's being factored in in this case. And I think that's what you should be looking at.

And the question is, what is the problem we are trying to address? The problem we are trying to address is that people in Detroit do not have healthcare coverage and Medicaid underpays. You are not solving that problem by building new hospitals in western Oakland County. The amount of money that even this amazing 9 percent profit margin will generate for the St. Johns Healthcare System is something like $18 million a year, and they are annually losing $100 million in Detroit. So that's not solving either their independent corporate responsibility, financial problem, nor is it taking care of the problems in the city of Detroit.

What we need are more doctors and more indigent health care and more subsidized health care. We need that money to be spent not on driving up the cost of business for their own patients, because that's who actually will be using these hospital beds in western Oakland County, they will tend to be the employed. Poor people don't have a high concentration in western Oakland County. We would rather have this money be used directly where the problem is. And further, that this will allow you to have a consistent approach to this.

We supported new hospitals. We supported your new hospital because it made sense in Flint to consolidate new hospitals and put it someplace else. But that was based on systematic study of the situation and overall downsizing of the system.

MS. TURNER-BAILEY: Any other questions? Dr. Ajluni, do you have a question?

DR. AJLUNI: I had one; he just answered it with his last comment.

MS. TURNER-BAILEY: Any other questions? Thank you. Jim Budzinski.

MR. BUDZINSKI: Good morning. I'm Jim Budzinski from Sparrow Hospital. And I'm somewhat reluctant to testify this morning. I don't have anything of the magnitude of what's being discussed this morning on my mind.

With our blue card I did submit some written testimony. I do have extra copies. I have purely some technical matters unrelated to the topics you have heard this morning to date. It has to do with some rules in the proposed October 7th rules that you have in front of you today, but a section that there are no revisions proposed to.

So you might ask why am I bringing this to your attention. It has to do with the December law Section 22209, Subsection 3(a), and I just want to bring to your attention that there may be some technical corrections to the proposed October 7th rules that you are looking at; in particular, under Section 7 covering the requirements for approval of replacement beds in a hospital in a replacement zone. My October 7th letter to you indicates that the lack of proposed changes to this section may be inconsistent with the December law, Section 22209, Subsection 3(a). And we simply wish that you address that matter and make those technical corrections to incorporate 209 Subsection 3(a) into Section 7 of the proposed rules dated October 7.

In addition, the second item I would like to bring to your attention, really purely a technical matter, Appendix A to the proposed October 7th rules as referenced to Sparrow Hospital that are technically incorrect, and it has to do

with the names of our campuses and the fact that there' s no footnote referencing that our two campuses are under a single license. I just simply wanted to bring that to your attention.

Sorry to interrupt this morning' s discussions, but I just needed to bring those to your attention I would be glad to take any questions at your discretion.

MS. TURNER-BAILEY: Any questions? Thank you.
Maryann Mahaffey?

MR. BUDZINSKI: Excuse me, Madam Chairperson. There is a question here.

MS. TURNER-BAILEY: Oh, I' m sorry.

MS. CHRISTENSEN: Do you believe the sub-area transfer standards that the Commission adopted a couple months ago do not deal with the transfers you are referring to?

MR. BUDZINSKI: Yeah, I think that' s also correct, yes.

MS. CHRISTENSEN: So the sub-area language that we adopted in standards which was meant to address the Section A transfers under 619, you feel there is a problem with that?

MR. BUDZINSKI: Yeah, I think there is technically a problem with that as well.

MS. TURNER-BAILEY: Any other questions? Okay, thank you.

MS. MAHAFFEY: I' m Maryann Mahaffey, President of the Detroit City Council. Council member Joann Watson sends her deepest apologies. We didn' t learn about this in time so that she couldn' t get released from a commitment she had made a month ago. So she' s asked me to convey her feelings on this. Her, if you will, testimony.

And I want to say, first of all, that government consists of three branches, as you all know so well. Judicial, legislative and executive. Ford Hospital representative, Ford Systems, presented a letter from the Mayor of Detroit saying he was in favor. The legislative body is overwhelmingly opposed, both to the standard and the movement of beds. We are opposed because, number one, the standards would allow new suburban hospitals even if a judge rules against them. And that does not provide any protection for the people.

Secondly, I would point out to you that Detroit is made up not only of poor people who are un- and underinsured, it' s made up of people of the middle class, it' s made up of auto retirees who have pensions, as well as auto employees. We are getting kind of tired -- yes, we do have low income people. We have people who are un- and underinsured. But we are getting kind of tired of the blame for the current problems in health care always being on the people who are un- and underinsured. We are getting kind of tired of hearing that the Detroit Medical Center is in trouble because of the un- and underinsured. That' s not the source of their problem.

Our city council had subpoenaed records, we subpoenaed witnesses, and to the best of our information we know that Receiving Hospital had a surplus until the year 2002. In fact, they had a surplus of $250 million, which was spent, as nearly as we can tell, very little of it was spent for Receiving and Hutzel. It was spend on, for example, buying hospitals in Oakland County. Macomb County. It was not spent in serving poor people. If that 250 million had not been siphoned off into those new hospitals, Huron Valley - Sinai, et cetera, there would have been plenty of money to carry the Receiving Hospital for ten years. And keep in mind they had a surplus up until 2002. So I would like to put that argument to rest, that DMC' s problem is not because of un- and underinsured patients.

DMC has a different kind of problem. And they have been, as nearly as you can tell, as we can tell, active in trying to desert Detroit, and that' s the way we look at it, in order to play out there in the suburbs where they think there's lots and lots of money. And I know I' m being very passionate at this point, but we feel very strongly about it.

And I would point out that if these beds, if this proposal goes through, then the Sinai - Huron Valley Hospital is going to be in trouble. Okay? They have a hospital out there. If there are more in there competing, they are going to have trouble. They are going to lose out. And so you help one and you punish another. And that won' t help the DMC at all, the Detroit Medical Center.

Right now, as has been mentioned, we don' t have enough primary healthcare clinics. And one of our problems- incidentally, my time is, I have one minute left? I will do my best.

We know that we need more primary, federally qualified clinics, and we are a little angry, frankly, that the Detroit Medical Center from the beginning decided they were going to get rid of their clinics which had the best chance of becoming federally qualified clinics. So, yes, we need federally qualified clinics.

We have to retain our Detroit doctors. Part of the hospital losses in Detroit are, yes, because 43 percent of the insured population in Detroit leave the city for their hospital care. And you need to look at why in order to make a decision. Maybe they need to improve their services in Detroit rather than running out to the suburbs and leaving us having to travel great distances.

I only know -- I mean, we have Receiving Hospital, we have others with emergency rooms that sometimes stabilize the patient and then send them to Receiving Hospital instead of doing what they are supposed to do to keep them there.

And we also know that as they move beds out, doctors go. And that we don' t have Urgent Care Centers in the numbers that we need. And St. Johns, for example, you are even either going to have to go to Riverview, which is downtown, and they are out in the far northeast corner of the city, or you are going to have to go out into the burbs. The suburbs, if you will. Yes, we sometimes call them burbs.

But the end result is people are scared to death. How far? And 34 percent of the people don' t have cars. And transportation is not that good. We are struggling to get an agreement among the region as to a better transportation system, but it depends on what those in the rest of the region are prepared to do. And so far they haven' t been prepared to do as much as would provide us with a good transportation system.

So we believe very strongly, and I speak for the majority, the overwhelming majority of the Detroit City Council, we do not believe that there should be special exemptions from the CON, and we do believe that there should be incentives for Detroit doctors to remain, and Detroit hospitals to maintain their service.

Because I dread to see the headlines when somebody living in the far northeast can' t get to a Receiving Hospital in time, can' t, and there is no Urgent Care Center. In the northwest side of Detroit, for example, we have a clinic at Outer Drive and Southfield. It has no Urgent Care Center. So where do you have to go? You have to go to Dearborn. How do you get to Dearborn? You have to have a car.

My friends, you are not my colleagues, though I would like to think we were colleagues in our interest in terms of the needs of the citizens of our city, that please, do not vote for this change in standards and to permit the hospitals to move out. It won' t solve our problems, it will just make it worse. Thank you very much.

MS. TURNER-BAILEY: Thank you. Are there any questions? Thank you. Amy Shaw?

MS. SHAW: Good morning. My name is Amy Shaw, and I am the Director of Education and Employee Relations for the Michigan Manufacturers Association. Thank you for allowing me to be here to share some brief comments with you this morning. And I will try to be very brief.

There is no need to repeat any of what has been covered in the joint statement of my position to the new standards that you have already received, and Larry mentioned them, the letter that we sent on behalf of Michigan Manufacturers Association and the Michigan Chamber of Commerce. I believe you have actually received that about three times now, so I think we are covered on that.

Instead, I would like to use my time to give you some perspective of why this issue is so important to the MMA and to our members. The MMA represents thousands of manufacturers across the state, big and small. Our

members collectively employ 90 percent of Michigan' s industrial workforce, and almost all of them, 97 percent, provide healthcare coverage for their workers. No other sector can claim that.

Their ability to continue to do so, however, is threatened by the already staggering and continually increasing cost to providing that coverage. That' s not news to anybody.

Employers voluntarily provide healthcare benefits for their employees. They are not required to do so; they choose to do so. And it is a decision that is reviewed closely every year. Employee compensation and benefits are based on what a company can forward to provide. As healthcare costs increase, employers must decide how to pay for that increase. Some have been forced to reduce benefits or increase employee contributions. Some have reduced the compensation side of the equation through lower starting wages for new hires, smaller raises for current workers, or a reduction of work force to offset the increased cost of health care. Many have reached the point that they can no longer provide any benefits at all.

Let me share just a few points of data from our recent healthcare survey to help illustrate the scope of the problem that we currently face.

Over 82 percent of the survey responded indicated that they are extremely concerned about the rising cost of health care, and 75 percent expect health insurance premiums to increase 11 to 30 percent next year alone. 72 percent ranked controlling healthcare costs as the number one issue of importance for their company. Over 22 percent reduced their work force and over 19 percent scaled back on hiring to offset rising healthcare costs. Almost half believe Michigan' s health insurance rates impede their company' s competitiveness. And 40 percent believe that rising healthcare costs threaten their company' s ability to remain in business.

So why are these statistics so important to what we are talking about here today? Because we believe that this is not just about beds, but this is about jobs. There are few aspects of healthcare costs that we can control. But CON offers the best cost containment measure that we currently have available. We cannot afford to do anything that would further increase the cost of healthcare benefits; especially right now while so many companies are struggling just to stay in the black. And we firmly believe that implementing the proposed hospital bed standards would undermine and could ultimately destroy the CON process, which is our best defense against unnecessary healthcare costs.

Thank you for your time and attention. And I welcome any questions that you might have.

MS. TURNER-BAILEY: Any questions? Thank you. George Hedgespeth?

MR. HEDGESPETH: Madam Chair, members of the Commission, good morning. Thank you for allowing me to be here this morning.

My name is George Hedgespeth. I am the Chairman of the Board of Trustees for the Oakland Region of the Henry Ford Health System, and I have served on the board since 1995. My role as a trustee is to represent patients and purchases of health care and to advise senior management of Henry Ford on decisions affecting health care in our Oakland region.

I am here this morning to urge the Commission to adopt the bed transfer standard for the following reasons: First, access for existing patients. The Oakland Region of Henry Ford Health System includes medical centers at West Bloomfield, Troy, Royal Oak, Novi, and Southfield. There are approximately a quarter of a million patients seeking their care from these Henry Ford ambulatory care sites now. This is equivalent to the populations of a small city.

As patients of an integrated health system in a Metropolitan region that has no hospital, these patients face difficult choices, interruptions in continuity of care, and extra costs when a family member requires a hospital stay. As an acute (inaudible) patient myself, I am very sensitive and keenly aware of the situation.

Cost effectiveness. As the former and now -- excuse me. As the former and now retired vice-president of finance and administration at Cranbrook Educational community, I am very sensitive to the impact of rising healthcare

costs on the bottom line. And I understand the underlying concern that this new Henry Ford Hospital will involve costs.

However, the issue here today is not whether there will be a new capital expenditure for healthcare services, but rather what kind of expenditures will be made and where investment and hospital services will be allowed. Our proposal for the West Bloomfield hospital is cost effective for several reason. We already have all of the components of a hospital except beds at this site. In addition, we have been advised by architects and financial advisors that it costs more to renovate existing, older hospitals than it does to build a new one. Hospital support services, administrative overhead, and physician offices are already paid for and are operational at the West Bloomfield site.

Also in today' s payment environment, hospitals are not rewarded for building unneeded beds. The old system of pass through payments for capital is long gone. Payments are now fixed by contractual agreement or payment formulas that penalize hospitals for unnecessary costs.

Third, balance. The Certificate of Need Commission has worked for many years to balance excess in costs using a mixture of hospital standards that allow continued investment at existing sites where there is an established patient base, or allowing new construction where there is evidence of population growth and unmet need. The Commission has allowed other institutions to add on to their existing campuses in Oakland County. For example, recent decisions on the Certificate of Need standards allowed 160 new beds at the Beaumont Hospital Campus. Additionally, the pending request for another 110 beds at Beaumont also illustrate this point.

The Henry Ford West Bloomfield Medical Center is another Oakland County site where there is a large and well-established patient base and where there is a growing population as well as unmet need. The inpatient facility that the proposed CON bed standards will allow is a long-planned extension of current services Henry Ford provides in our community, and completes the cost-effective integration of services that is the hallmark of the Henry Ford Health System throughout southeast Michigan. The hospital at West Bloomfield would maximize existing investment in a way that is cost-effective to patients and purchasers of health care in the Oakland County Region.

And finally, fairness. The Certificate of Need standards on hospital beds cannot be viewed as isolated from the rest of the healthcare environment. Today one of the biggest issues related to the CON is uncompensated care and the ability of hospitals and communities to finance this cost. The Michigan Hospital Association estimates that Michigan hospitals contribute over $800 million per year in uncompensated care due to the growth of people without insurance and Medicaid underpayments. Citizens and businesses in Detroit currently finance nearly 50 percent of this statewide cost because of the concentration of patients in Detroit that don' t have insurance or are on Medicaid. Other communities in Michigan do not experience this burden at this magnitude.

There is no quick fix. However, the legislature did view the ability of Detroit health systems to diversify their overall payer mix as part of the solution. The matter has been given priority because the legislature knew there would be no new revenue in the state or federal budgets to address these payment gaps. Independent hospitals and high occupancy hospitals have been provided growth opportunities through CON standards designed to meet their needs. Unfortunately, these measures do not help with the special needs and circumstances in Detroit.

The Detroit-based health systems must be allowed to compete and grow in order to survive and continue their mission in Detroit. Thus, adoption of the proposed bed transfer standard is a matter of great urgency and fairness. It is the only means available, outside of significant new state revenues, to allow the Detroit health systems to address the extraordinary financial challenges that they face today and also in the future. I would respectfully urge your adoption of the bed transfer standard. And I thank you for allowing me to speak today. Thank you.

MS. TURNER-BAILEY: Are there any questions? Thank you. Cheryl Miller. Cheryl, I' m sorry, we are going to take our break now, and you will be the first speaker when we come back. So ten minutes and we will reconvene.

(A recess was taken from 10:30 to 10:45)

MS. TURNER-BAILEY: We are going to reconvene. Cheryl, would you mind stepping to the podium while everybody is being seated?

MS. MILLER: Thank you. I' m always grateful when podiums aren' t so tall. When you are so short, you sit back there and you sweat it out, am I just going to be eyes appearing over the top?

My name is Cheryl Miller. I' m Senior Manager in Trinity Health' s corporate strategic planning office. Thank you for the opportunity to comment on the proposed CON review standards for hospital beds.

Trinity Health is sympathetic to the plight of health care providers in Detroit who are facing a financial crisis due, in part, to the provision of the disproportionate share of uncompensated care. Trinity was forced to close Mercy-Detroit Hospital in 2000 based on run rate losses from Medicaid managed care and uncompensated care that led to operating losses exceeding $24 million a year. The Executive Branch and the Department of Community Health at that time declared victory over the closure of this excess capacity.

A swift and dramatic change in public policy is essential to tackle the problems of cost and access to care for the uninsured in Detroit. We support and advocate for change in public policy, including the formation and funding of a Public Hospital Authority, to include Detroit-based providers in tackling these problems.

Building 900 new beds in western Oakland County will not solve the Detroit hospitals' financial crisis and will actually exacerbate the problem. New hospitals will not provide a return on investment to offset uncompensated care losses. New hospitals will weaken many of the existing suburban hospitals that have excess capacity now and will put their charitable mission as risk.

The provision of Public Act 619 that allows for the construction of new suburban hospitals is not based on thoughtful health resource planning and it adversely impacts cost, quality and access. The proposed changes in the CON standards implement the same bad public policy that is part of PA 619.

Trinity Health has long supported the Certificate of Need program. While the CON process is not perfect, there is published evidence from major employer groups in Michigan that have been alluded to and referenced this morning that it has been successful in balancing important goals in cost, quality and access. As healthcare costs continue to rise, manufacturers are increasingly concerned about their continued ability to maintain a strong workforce in Michigan. The construction of unnecessary hospitals will not help this growing dilemma.

Other providers have been forced to follow the rules and use CON to obtain approval for beds and other expensive healthcare resources. If the CON Commissioners agree to the proposed CON standards which grant the exclusive franchise to three health systems in Detroit, it will be the most significant opening of Pandora' s box to date. There will be a proliferation of end runs around the CON process by other providers. All it will take is enough lobbyists and lawyers to make it happen. It will inevitably lead to the end of CON as we know it.

As others have referenced this morning, the Technical Advisory Committee to the Bed Need Ad Hoc group is within a few meetings of finalizing their recommendations. Given how close we are to seeing more accurate bed need numbers and sub-area groupings, doesn' t it make sense to stay the course just a little while longer, at least until the December CON Commission meeting? This would mean that the need for additional beds could be made based on actual demographics, use rates of inpatient services and technology. Thank you again for the opportunity to speak, and I urge you to say no to the new standards at this time. Thanks.

MS. TURNER-BAILEY: Are there any questions? Thank you. Dave Kaser.

MR. KASER: Members of the Commission, thank you for the opportunity to offer a few short comments. And they will be short because, regrettably, I have been upstaged by a planner earlier this morning. Mr. O' Donovan from Beaumont hit on my main subject.

I' m not here to speak for or against the proposed standard bto raise a concern that perhaps you want to call it a technical issue, call it what you wish, but I think it is a significant issue that you and your drafters may want to take a look at.

MS. TURNER-BAILEY: Excuse me. I don't you to interrupt, I apologize, but for the record I need you to introduce yourself.

MR. KASER: I beg your pardon. My name is Dave Kaser, K-A-S-E-R. And I'm here from the Miller Canfield law firm in Detroit.

The subject that brings me here is that of, I guess we call it the scope of these standards. And Mr. O'Donovan spoke to it when he mentioned that as he and others read these, and as I read these, these standards could apply virtually anywhere in the state.

Clearly, from listening to the numerous speakers today and the speakers at the various hearings that have been held on these standards, this is a southeast Michigan issue. These standards are southeast Michigan in their origin and their concern. My request of you today is that you provide language in the standards that clearly restricts their application to southeastern Michigan, which I believe is your intent.

The only other matter that I would bring to your attention is that on the second page of the red lined standards, in line 69 is a change which changes the language referencing a decision of the court of competent jurisdiction, striking the term final decision, so that it now reads simply a decision of a court of competent jurisdiction. The pending litigation, as your competent legal counsel, I'm sure, can tell you, that decision will apply to the litigants involved in that case only and I don't think will apply to this Commission because I don't believe this Commission is a party to that lawsuit, is it?

MR. STYKA: No, it's not.

MR. KASER: And consequently the Commission may wish to ask itself and its legal counsel what effect this is going to have on the enforceability of these standards by those left to enforce it once that court case either is concluded or is on appeal should this language stand as proposed.
Thank you. I have nothing further. But once again I ask you to take a look at the scope of the standards before you. Are they limited to southeast Michigan, and if there is any question that they are not, please include language that ensures that that is the scope of the standards.

MS. TURNER-BAILEY: Are there any questions? Yes, Commissioner Sandler?

DR. SANDLER: Yes, I have a question. You identified yourself as a lawyer from Miller Canfield.

MR. KASER: That's right.

DR. SANDLER: A highly reputable firm, by the way. But you are not here as simply a concerned citizen.

MR. KASER: I represent a hospital system not in southeast Michigan.

DR. SANDLER: Like who?

MR. KASER: Covenant Healthcare System in Saginaw and several small hospitals in outstate Michigan.

DR. SANDLER: And you are representing those interests in your testimony today?

MR. KASER: That's right.

DR. SANDLER: Thank you.

MS. TURNER-BAILEY: Any other questions? Thank you.

MR. KASER: Thank you.

MS. TURNER-BAILEY: I apologize in advance if I mangle your name because I can't read your writing. Peg Reihmer?

MS. REIHMER: Reihmer.

MS. TURNER-BAILEY: Well, that wasn' t too bad.

MS. REIHMER: Good morning. My name is Peg Reihmer, R-E-I-H-M-E-R, and I am Vice-president for Planning, Marketing and Developing for Botsford General Hospital in Farmington Hills, Michigan.
Botsford is a 330 bed community teaching hospital which offers a broad array of general and specialty inpatient and outpatient services, and we are an independent hospital.

I' m here today to urge the Commission not to approve the proposed amendments to the Certificate of Need Review Standards for hospital beds. I' ll speak not to the specific language of the standards which seem well crafted for what they intend to do, but to the underlining premise which is contrary to the purposes and intent of the Certificate of Need law.

Building new suburban hospitals without a clear demonstration of need is an inappropriate and irresponsible response to the considerable financial challenges facing our urban hospitals.

As we have testified in the past, the new hospitals proposed by Ascension Health and the Henry Ford Health System will not generate sufficient margins to materially offset losses from the inner-city operations. They will, however, have a chilling effect on hospitals currently serving the population from which they wish to draw patients and will adversely impact cost, quality and access.

The number of admissions necessary for these hospitals to operate at a reasonable level of efficiency far exceeds the number expected to come from market growth. These hospitals will not be able to grow and achieve profitability without taking patients from existing hospitals, hospitals which are valuable community resources providing necessary services. This will weaken existing hospitals, forcing the consideration of reduction or elimination of services. Some hospitals currently struggling may be forced to close. At Botsford, the closest facility to the proposed sites, we anticipate that we would experience not only an overall reduction in admissions, but a deterioration in our payer mix as well. Ironically, two of the facilities most likely to be harmed by this ill-advised proposal are Huron Valley-Sinai and Sinai-Grace Hospitals, two of the only profitable hospitals of the Detroit Medical Center, which is the unquestionably the most financially challenged health care organization in the state.

Construction of unneeded hospitals in Oakland County will also have a negative impact on costs. Estimates of the capital investment associated with these new hospitals are approximately $450 million. The annual debt service alone of the hospital project described by the Henry Ford Health System in a Notice of Intent filed earlier this year was $16 million. Or if they operated it at 75 percent occupancy, $195 per patient day before anybody ever touches the patient.

Surplus capacity drives up aggregate demand and creates over-utilization, increasing costs for payers and consumers.

We do not believe that there is a need for additional hospitals in western Oakland County. Hospitals within a ten-mile radius of the proposed sites experienced average occupancy of about 50 percent in 2002 and can easily accommodate anticipated market growth. Residents of Novi and West Bloomfield and the surrounding communities are well served by the extensive and sophisticated ambulatory facilities operated by the proponents of the two hospitals. These are not underserved communities.

The Commission currently has an active Ad Hoc on Hospital Beds examining whether changes should be made to the methodology for determining the need for beds. I sit on the Technical Advisory Committee to that ad hoc. We are, in fact, meeting tomorrow, as you have heard, and are no more than weeks away from making recommendations that will ultimately come to the Commission. This work should be completed, and if, as a result, it is determined that additional hospitals or hospital beds are needed, they should be subject to Certificate of Need review and all applicants should be given a chance to compete based on the merits of their proposals.

I thank you, as always, for the opportunity to speak with you and for your attention this morning.

MS. TURNER-BAILEY: Are there any questions? Thank you. Rich Alverson?

MR. ALVERSON: Good morning. My name is Rich Alverson. I'm Manager of Legislation and Program Initiatives for DaimlerChrysler Corporation. And we at DaimlerChrysler are very much opposed to the Michigan Department of Community Health proposal to revise the CON hospital standards.

We already have a very seriously overbedded situation in Oakland County. Allowing additional beds in Oakland County will exacerbate the situation and worsen the future healthcare inflation in southeast Michigan. DaimlerChrysler and the other autos are already fighting double-digit healthcare inflation. At DaimlerChrysler, for example, our average increase over the last five years has been 10 percent a year. At the same time the three autos are losing market share to the transplants, and because of the competitive pressures were unable to raise car prices. Keeping healthcare inflation in check is essential if Michigan is going to have a viable auto industry and a healthy state economy.

We fully recognize and appreciate the problems that are faced by the Detroit hospitals with the heavy losses that they incur due to the uninsured and underinsured populations. Unfortunately, moving beds to Oakland County would do very little to help the overall plight of Detroit hospitals. At the same time, they will do considerable damage to the Oakland County system.

The MDCH proposal is clearly the wrong answer to a very serious hospital problem in Wayne County. It could also lead to an explosion in healthcare costs in Oakland County. I think it is very important in this situation that we not try to treat a fractured left arm by breaking the right arm. Thank you. Do you have any questions?

MS. TURNER-BAILEY: Are there any questions? Thank you. Bob Hoban?

MR. HOBAN: Good morning. I think it is still morning. Yes. I just wanted to give you an update. You have heard a lot from me over the course of several meetings. We have been working with the department on these standards. We met with the Economic Alliance of Michigan to help craft these standards that capture the intent of the legislation yet significantly limit the scope of permissible bed relocations under these standards.

We believe the result in front of you today is a good outcome of this effort and represents good public policy. And I will talk more to that in just a moment. We believe the standards optimize access to care while reducing the cost to health care.

There is a clear need for greater access to health care in western Oakland County. I think that's pretty undeniable, that there is a tremendous need in western Oakland County. There is one small facility in the entire western half of the county. Access there is very, very limited.

The standards will allow the addition of two facilities of 300 beds or less and allows for the expansion of the current facility that is there by a like amount. One of the things that is getting confused today, though, is we are not asking to expand beds; we are transferring beds. This is very different than coming to you and asking you for new beds. In the case of St. Johns Health, it is our full intent that the beds that we are relocating to Novi would come from St. John Oakland in Oakland County, Providence Hospital in Oakland County, and from our Brighton facility in Livingston County. We are not moving beds out of the city of Detroit to Novi. We have said that from the get-go, and that is still our intention, to relocate beds primarily from within Oakland County, from the Eastern half of the county to the western half of the county.

We are not asking for an increase in the bed count, we are just trying to move the beds to get them to a point where there is better access to care for the population of western Oakland County. We are giving up beds at the same time in Eastern Oakland County, which is heavily overbeded. Let's talk about the cost for a minute. We all know that the opportunity to pass capital operating costs on to third parties is virtually nonexistent. And I'm sure the hospital CEOs who are represented on the Commission can speak to that as well. The ability to pass these costs on to third-party payers is not there. It's not like we can raise our prices and the costs suddenly appear to be higher for the payer's. Our reimbursements are fixed, and we are at risk for the cost of the projects from the payers perspective. Actually, the addition of the facilities, as I said before, will most likely reduce the cost to health care to the manufacturers and to the unions.

Facilities that now enjoy some leverage with various third-party payers because of their size or geographic presence, particularly around the Oakland County area, will be forced to negotiate more aggressive lower rates with payers in the future. This will actually reduce the cost of health care for labor and for manufacturers and business. This will not increase their cost to health care.

The question is what happens to the capital cost that we spend. We will absorb that cost. Is it additional cost in the overall health system in the long run? No. What will happen in the long run is this, the cost expended there will be offset by costs that won' t be expended as they are currently now.

Facilities are spending hundreds of millions of dollars to upgrade and renovate their existing facilities to accommodate that patient demand from western Oakland County. And the cost of renovation is more expensive than the cost of new construction. In the long term, the expenditure of these capital dollars in western Oakland County will be offset by the fact that some projects in eastern Oakland County and other areas will not occur, and that capital cost won' t be spent to address the needs of patients in western Oakland County.

Operating cost. The operating costs also are not passed on to the payers. The variable costs, such as nursing salaries, will shift to the new facilities. It will incur some additional fixed costs; however, these are minimized in light of the fixed cost infrastructure that exist at all three western Oakland County sites.
You have heard our competitors speak about potential losses they will incur. They will not incur additional fixed operating costs. They will incur some loss of profitability because of their inability to spread their fixed costs over a greater patient base.

The hospital that' s going to feel this the strongest is none other that Providence. Currently 30 percent of the patients at Providence come from the service area of Novi. And they will suffer the greatest loss of patient base due to the addition of these facilities in western Oakland County. And I assure you, we have looked at it, and Providence Hospital will remain a financially viable entity after the construction of the facility in Novi and the construction of the facility in West Bloomfield. They will suffer the greatest loss of patients, and yet they will still be viable.

The projects that result from these standards will optimize access to care while reducing the cost to care of payers. And I need to spend just a minute, now, talking about why I offered this opportunity to the Detroit hospitals.

MS. TURNER-BAILEY: You can' t spend much more time because your time is up. So try.

MR. HOBAN: I will. I wanted to respond to some of the concerns that were raised in the room.
You are very well aware of the market we serve. This is not the sole solution. We are forced to make very difficult choices. Last week we took St. John Northeast out of the inpatient business. We made the decision to transition it out. We had two community hospitals and two tertiary hospitals serving the citizens of Detroit. We still have two facilities located on the east side of Detroit. We still have in excess of 850 beds located within the city limits on the east side of Detroit. We are not abandoning Detroit. We are not moving the beds from northeast out to Oakland County. That is not occurring.

These two community hospitals were half full and were losing millions of dollar annually on a combined basis, and we were forced to consolidate that infrastructure to save some costs. We needed to maintain the financial viability of our Detroit access and minimize the negative impacts on access to care.

We are maintaining 24/7 emergency services at the St. John Northeast Campus with ambulance backup to transport patients, should they need it, to one of our other facilities.

We are also enhancing access to primary care. The area bounded by Northeast has the lowest ratio primary care physicians to population of anywhere in the state of Michigan. And so we are very committed to getting a stronger primary care base in that and there will be access to urgent emergent care services.

Access in Detroit, this is not an A versus B decision. It' s not like if you move a hospital to the suburbs odon' t that impacts whether you stay in Detroit or not. They are two unrelated decisions. A presence in the suburbs will

allow us to subsidize care in Detroit; not moving forward will just enhance the potential for further closures in the city of Detroit.

We do have the support of the Mayor of Detroit. We feel that we have the support of some members of the city council. I did note that no resolution was offered from the city council, and I would suspect if there was a majority opinion on the city council you would have seen a city council resolution in front of you. In summary, it' s greater access to care. Reduced cost to payers. It' s a partial solution to Detroit. It' s good public policy. And I thank you for your time. Sorry I ran over.

MS. TURNER-BAILEY: Thank you. Are there any questions? Did I understand you to say during your testimony that you are not moving beds out of Detroit, you are transferring beds within Oakland County? So you are essentially saying your situation is different from what Henry Ford is proposing to do, which is to move beds out of Detroit into Oakland county. Is that correct?

MR. HOBAN: Right, it is different. We do have different initiatives involved there. But the key thing is neither one of us is adding to the bed capacity in the healthcare system. We are both transferring beds. This isn' t a high occupancy proposal where we are asking for additional beds in the healthcare system, we are reconfiguring bed assets to better meet the demand of the population. We are not asking anyone to add one bed to the healthcare system in the State of Michigan, we are just asking for the flexibility to reposition those beds to meet the needs.

MS. TURNER-BAILEY: Any other questions? Thank you. Brian Reuwer?

MR. HOBAN: May I make one last comments? There are letters of support, I think, on the corners of the table from some of the legislators in the Detroit area.

MS. TURNER-BAILEY: Dr. Ajluni, would you mind starting those around?

DR. AJLUNI: These are not those.

MR. REUWER: My name is a Brian Reuwer, and I represent the Michigan State Medical Society. I had not intended to speak today, but I just wanted to address a few quick points that were brought up in earlier testimony.

We are supportive of the proposal that is before you right now. We supported the legislature' s actions when they originally inserted this language into the legislation. We did support this legislation, contrary to some of our past comments on the Certificate of Need.

I wanted to take, I just wanted to discuss very quickly this memorandum right here and the $500 million additional costs that this will add to the healthcare system. This is not new money. This is not something that is just going to spring forward, these costs. These costs are currently being borne by providers in Detroit through their uncompensated care through the uninsured and the increased reimbursement through Medicaid by the state. This bed transfer will not solve the problems of Medicaid. We understand that. The hospitals understand that.

We are part of a coalition with the Osteopathic Association, the hospital associations to fix other problems with Medicaid. This will not solve all the problems, but it will help. And it is important to get -- it is important to help the hospitals to help them take care of the population in Detroit, the uninsured, and the Medicaid population. There is a need for these beds in western Oakland County. I think the legislature did address that, and I hope that you will address that as well and allow these beds to be transferred.

That is really all I had to say. I just wanted to offer that little bit, this is just going to help. It is not going to fix the problem. That is something that we are going to need to do as well, but we -- this will help. This will help greatly.

MS. TURNER-BAILEY: Thank you. Are there any questions? James Ball?

MR. BALL: Thank you and good morning. My name is James Ball. I am the Assistant Director of healthcare plans for General Motors Corporation. I also serve as chair of the Ad Hoc Advisory on Bed Need, and it' s not in that capacity that I' m here to talk to you this morning.

We at General Motors oppose the standard that's before you this morning and want to encourage you not to act on it but to, indeed, if there is an issue after the court acts, then to act in a more deliberate manner to consider what is appropriate. The little booklet that you have that you hand out in the back of the room today talks about the Certificate of Need being a state regulatory program intended to balance costs, quality and access issues and ensure that only needed services and facilities are developed in Michigan. I submit to you that contrary to some people's statements that there is clearly a need that's been established in western Oakland County, I don't know how they concluded that there is a clear need when there is underutilized capacity that exists in the area at the present time. If you venture into the area beyond what your assigned task is and venture into this area of finance and areas of social good, then I think it is incumbent upon you not to move rapidly through this process but to have a full and more complete discussion of what would be the impact of your action.

You have heard people say we are not moving occupied beds, we are moving excess beds. Well, why would one spend $500 million or more to create a warehouse for excess beds? Then they change, well, we are actually moving beds that are in use. There are people we are serving in other areas and we want to make it more convenient to serve them closer to their home. But then they turn around and say, but we are not going to diminish anything we are doing at the facilities that we are moving the beds from. I would submit to you that over time they will move other services to the new hospitals, and the old hospitals, the staff will move to the new hospitals, services will move to the hospitals or be replicated and the old hospitals will, indeed, cease to fulfill the mission that they have been fulfilling in the past.

I think the myth has been debunked that the actions being requested here are going to save the Detroit hospitals. I think even the last speaker conceded that this will not save the hospitals. And this issue of convenience, expanding capacity just for the purpose of convenience is not sound Certificate of Need practice.
I will be happy to entertain any questions.

MS. TURNER-BAILEY: Are there any questions? Thank you. Terry Gerald?

MR. GERALD: Good morning. I think it is still morning. It has been a long morning.

My name is Terry Gerald. I am Corporate Director of Government Affairs for the Detroit Medical Center, and I thank you for giving me an opportunity to present a few very brief comments this morning. I know you have heard many of the arguments on all sides of the issue today, and on numerous other occasions, and I won't rehash those. I just want to make a couple comments on behalf of the Detroit Medical Center.

We do believe these standards will create an opportunity for us to balance our payer mix in the future and without jeopardizing access to care in the city of Detroit. Our current unreimbursed care at the DMC is projected to be approximately $120 million in FY '04. This has been fairly consistent over the years; however, in fact, I should say it has actually increased recently over recent years. So that burden is continuing for us. For the DMC, now, as you know, we have a great financial crisis that we are facing right now, and, therefore, many, many unknowns, particularly with the proposed Public Health Authority, and we are not sure where that's going to go, and other changes. And we believe that the flexibility to address these potential changes as we go forward to address our very, very serious financial crisis is critical. Therefore, we strongly encourage you to approve these standards and to move them forward. And I thank you for this opportunity, and I would be happy to answer any questions.

MS. TURNER-BAILEY: I have a question. I have to turn my mike on. There have been several comments today made that, in fact, these changes, should they go forward, would actually hurt the DMC versus help them. Would you like to make a comment on that?

MR. GERALD: Yes. I have heard those comments. And we have to evaluate risks and the impact of these against opportunity. And for us right now, granted there are always risks that we are not exactly certain how this will play out, but for us the most important thing to us is to have the opportunity and flexibility to adjust our bed complements and our services to the changing environment and the market in which we find ourselves. Therefore, this provides that opportunity. And to us that opportunity is the most critical piece right now, because there are many unknowns, and we just don't know what's going to happen. And its absolutely essential that we maintain maximum flexibility as we move forward to address these issues.

MS. TURNER-BAILEY: Are there any further questions? Thank you. You may have heard a note of finality in my voice when I called Mr. Gerald's name, and the reason is because that's the last card I had, and that will conclude our public comment section of the agenda.

Moving on really to the discussion, section, are there any comments? I really, I would like to also give the staff an opportunity to, if you'd like, to talk about the language and the changes that we have seen highlighted here. You know, obviously, if any of the Commissioners have any questions, we should hold them time. Jan?

MR. CHRISTENSEN: Thank you. We have supplied the document, and it has been a long process, beginning, I think, actually in December of 2002 when the legislation was first passed and deliberations at that point in time. Since that time, as you noted, the Commissioners have had several opportunities to look at various drafts of the standards.

What we have endeavored to do along the way was to take a middle course, a middle-ground course between what is the clear language in 619 -- and one of the dangers there is Subsection C that allows hospital-to-hospital transfers within an HSA on an almost unlimited basis, we think perhaps as much as 10,000 beds in play under C -- and the issues under Subsection B that allow the two FSOF transfers. That is being litigated, as other individuals have reported today, various issues in that.

What the standard attempts to do is take a middle-ground approach and to try and meet the intent of the legislature when they passed 619. But to do it in a very restrictive way; preserve, to the extent possible, the CON program by limiting the number of beds that could be transferred. So as you have seen the standard evolve over three Commission meetings and lots of testimony, you have seen limits being put in there. And we have in the new standards highlighted in red for the Commission members and underlined a number of sections that increase the restriction on these standards so that they are highly focused for you.

This was as a result of some hard negotiations with the folks who wanted 619 passed in the first place. They, in many cases, had to compromise down from the wide-openness of the provisions under 619 to a very restricted amount of transfers. For example, under Subsection B we have FSOF transfers. There is language that could be interpreted as one for two staff beds up to a maximum of 100. Maybe that sounds like 200 beds, but there is no explicit language in B that says no more than 200 beds to an FSOF, and you could make an interpretation that there isn't any limitiin B. You could transfer under B to an FSOF 300 beds, 400 beds or 500 beds. There is clearly no limit under C for bed transfers. So what we attempted to do was take a middle-ground approach and say, What are we really trying to accomplish here?

Part of this whole process of the standards, from the view of the department, was to accomplish one of the principals of the CON program, which is access to care, accomplish the intent of those who were involved in the passage of 619 to allow for a limited number of transfers to provide some assistance to large urban hospital systems that are experiencing significant financial problems. And in all the testimony over the last three months I have heard a number of people say this isn't the total solution. And We said, it isn't the total solution. But it is a significant part of the solution.

The executive branch of government, in cooperation with the city of Detroit and the Wayne County Executive has had a Wayne County planning group looking at the problem in the city of Detroit in terms of health care delivery, and that planning group has said there is a shortfall of about $240 million. And it comes from a variety of arenas. We need to find ways of filling that shortfall.
On the other hand, I have not heard anyone say, who has said this isn't a total solution, I haven't heard them say they would support an increase in the sales tax, an increase in income tax, an increase in the single business tax, an increase in a revenue source that would help provide that support. By way of background, the Detroit Wayne County Health Authority, as it is being formulated and planned as we speak, and being put together, will look for a variety of sources of funding. And there isn't any one single solution. We can't go to private foundations, we can't go back to the state legislature and ask for additional funding to the magnitude that's needed. It isn't there. Won't be appropriated if asked. It simply is not possible to raise that kind of revenue.

We have experienced an increase in the Medicaid caseload in the State of Michigan by over 10,000 individuals per month for the last three months running. That's a tremendous increase in the burden of the caseload. Unfunded caseload (inaudible). So we have a massive state shortfall in the 2004 budget and perhaps even a

worse shortfall in ' 05. So much so that there is a (inaudible) estimating conference coming together to try and figure out the magnitude of the shortfall. We know it is significant. It is several hundred million dollars. In that regard, to suggest that the state legislature can fix this problem with new appropriated funds is naive. It is not going to happen. There may be some adjustments that can be made, but it is going to take all of the partners: More federally qualified health centers, improved payer mix as might be provided by this standard, increased maximization of federal revenues. Although we have been doing that for years and we have just about used every trick in the book to draw down maximum federal revenue to the point where the federal folks are re-reviewing some of the things they approved in the past to see if they can close what they perceive as loopholes and we perceive as opportunities to maximize revenue. So that is the purpose why the department has taken this middle-ground approach.

I have, since the last meeting, met personally with the co-chairs of the Legislative Oversight Committee, Representative Ehardt and Senator Hammerstromm, and both of them have indicated to me they support the standard, they would like to see it passed, and they would work for a technical correction in 619 to close some of the bigger loopholes if that was deemed to be necessary by the Commission and by the department.
The executive branch of government. I have talked with the Office of Legislative Affairs for the Governor. Janet O' Shesky, my boss, has talked directly with the Governor. We believe we have strong support for fixing what is a technical problem with 619, the broad breath of it. So we think we can do that. We think we can accomplish that in a very short order if allowed to do so. In order to do so we need a standard to accomplish the legislative intent. We have also met with the staff of the senate majority leader and provided them with the same information, the necessity for a quick repeal of certain technical amendments that we need in 619 to bring it back in line and strengthen the CON program.

So we have attempted to take the middle-ground course. It is not a political approach at all, it is rather apolitical, and it is an attempt to recognize that the legislature does provide oversight, has an oversight committee in the CON Commission, and that they have expressed their intent that these types of transfers that will assist access of care and payer mix in the city of Detroit is particularly important. The legislature in the ' O4 budgets appropriated an additional $50 million to help assist temporary bridge funding to the Detroit Medical Center. That was their effort to come up with their share of the solution to this problem. It is going to be difficult during ' 04 to maintain that. We expect early reductions. The Governor mentioned there might be executive order reductions in the ' 04 budget already, and the ' 05 budget, as I say, looks even worse. I think the standard is pretty straightforward. We have made a couple of minor changes. Page 9 of the standards I would like to highlight the fact that we have reduced the time frame from five years, which would be ' 08, down to ' 07, which is four years, so that all of these transfers have to happen within a defined time frame. That is an additional restriction over what was in the statutory language of 619. We have indicated that it needs to be evaluated by the Commission and affirmatively renewed, if they care to do that, or let to expire.

Some of the confusing language that we had in there we have cleaned up on recommendations of various individuals since the last Commission meeting. Most notably, on page 12 we have deleted that Section F. There was some concern on line 592, there was some concern that all that language might allow some transfers that were not consistent with the original legislative intent of 619. We have cut all of that out. We have indicated just above that on line 580 that the maximum number of beds being reallocated by a health system cannot exceed 300 for any combination of FSOF to hospitals. So we have limited very strongly each health system to a transfer of 300 beds, and that caps it. And that' s, in fact, quite a bit of a reduction compared to the current authority under the current statute that they have. Again we have repeated the language on line 609 through 612, it says this thing expires in four years. The Commission has an opportunity to evaluate it and decide whether they want to continue it or not, or just let it expire. This gives the Commission an opportunity to gather the data on the net result of these standards on whether or not the payer mix has contributed to the solution as we believe it will and as the legislative people who passed 619 believed it would.

We simplified some of the other language I put in a one-page sheet that I think was left at your tables. There are a couple of technical amendments. We have also put them on the table in back. We tried to get rid of some of the confusing language that was in 619 where it said going by, under the control of, or affiliated with. We tried to get rid of all that and change that to wholly owned. When we did that, we simplified that down so low in this draft standard that our attorneys and others have advised us -- internal to the department, not the AG, I don' t want to suggest he has given us this advice, although he might -- that wholly owned may not cover the type of technical corporation ownership that we see, but we have a common corporate parent corporation that serves as a sole

member, a shareholder for subsidiary hospital corporations, which is the format of business at the Detroit Medical Center and several of the hospitals. So it is still wholly owned, a system of hospitals, at least two hospitals that are wholly owned or have this form of corporate ownership or affiliation. We also indicated that this is limited to cities of population of 750,000 or more. We do believe, as someone suggested, that there are urban areas in addition to the city of Detroit over time that may experience similar situations. Large urban areas that come together, if they reach that level of 750,000, may indeed experience similar payer mix problems, but it is an issue for the Commission to consider at a future date. We did indicate that they had to have -- these are largely restricted to large urban systems, so they had to have at least one licensed hospital of no fewer than 500 licensed beds on or after January 1st of 2000. And finally, the other amendment really goes to lines 563 and 564. The one for two bed transfers up to a limit of 100 beds, one for two staffed beds actually was originally intended in the legislation to apply to FSOFs, not to hospital to hospital transfers. And what this does is it corrects that. We had in the draft standard included it for both, but we have received considerable comment from various individuals that it doesn't need to do that, it should go back to the intent of the legislation. So it is one for two staffed beds from FSOFs that are transferred, not existing licensed beds.

The department feels strongly that this middle-ground approach is a viable way to deal with this very difficulty problem. There are no perfect solutions. We think this is an solution that will provide some important relief to the Detroit health systems and will allow them to continue their mission of providing services to the city of Detroit. I do not expect the Medicaid caseload will slow down anytime soon. It hasn't. We are now reaching record levels of Medicaid for the caseload, and perhaps even more uninsureds in the state. So the difficulty of the payer mix is an important one that we are interested in seeing this standard pass to address. That was part of the deliberations in the legislature when the standard was originally debated. We think it is on target. It is an issue. It's not a perfect solution, but it is part of it, and we need to work on this and other parts as well. We urge the Commission to vote for this standard. Thank you.

MS. TURNER-BAILEY: Any questions? I have just one quick question. It was brought up about the language, page or line 65 to 74 relative to the deletion of the words the final. Can you comment on the significance of that change and what that might mean?

MR. CHRISTENSEN: The original wording was that it would take effect in the event there was a final, as it was noted there, final decision from a court of competent jurisdiction. In discussing this term, it could be interpreted to mean a final decision of the Supreme Court, I guess, and that's not normally what happens.
What normally happens is a court of competent jurisdiction makes a decision. Perhaps there is an appeal to the appellate court. But if you leave it the way it's written, you go way beyond that and potentially tie up an answer to this case for a significant number of years. The idea was a court of competent jurisdiction making a decision would allow the standard to go into place. We were in dialogue with Ron Styka on that.

MS. TURNER-BAILEY: Any other questions for the department relative to the language? No comments? Questions? Discussion? I think we have worn ourselves out here. No more energy.
Certainly the next item on the agenda is action, which is for the language that is before us today and relative to the testimony that we have heard not only today but on several other occasions.
I'm going to just make a quick comment while I'm waiting for a motion, and that is I'm actually, I was a little bit dreading, sort of, this constant hearing of public testimony. You know, I originally thought we would hear the same thing over and over, which to an extent we did hear confirmation of positions all the time, but certainly I feel that I heard something new and useful each time that we had an opportunity to hear from the public. And so I really appreciate that.

I think for myself the issue, even notwithstanding whether or not this language or the legislation puts forth a complete solution to the problems in the city of Detroit or with the hospitals, certainly I think we should consider the effect on the CON itself and its process as we look forward to this language. I have a concern that the Commission has a process that has worked so far, and that it is in place relative to looking at bed needs, how we should move forward with the allocation of beds and evaluating the needs of beds. We have been told today on a couple of occasions that we will have an opportunity to see the results of that review in a very short period of time. And it is my thought that if the CON is to maintain its processes, that we should follow those processes. And I think passing language like this today takes us out of our normal operation.
That's just a comment that I have. You know, any other comments are welcome; if not, a motion would be in order.

DR. SANDLER: I just have one other comment. That one of the concerns we had at earlier meetings was 3(c), the hospital-to-hospital movement of beds with virtually no limitation, I believe the department thought as many as 80 possibly, it was the feeling of the department or feeling of the people trying to preserve the CON process, that needed to be addressed as soon as possible. And that was, if not the genesis of the voluntary standard we are about to vote on, it certainly was a very important reason for voting on it. And the department has urged the vote and has urged the vote to approve the standard, and that is a significant reason for doing that. This will preserve the CON process and will prevent hospital-to-hospital movements across the state. Thank you. And I would make a motion to approve -- I would like to make a motion to vote on the voluntary standard.

MS. TURNER-BAILEY: You are making a motion to vote on it.

DR. SANDLER: Correct.

MS. TURNER-BAILEY: You are not making a motion one way or the other about the language itself? I just want to clarify what your motion is.

DR. SANDLER: The motion is to vote on the standard with the technical amendments in front of us.

MR. STYKA: So you are making a motion to adopt?

DR. SANDLER: Yes.

MR. STYKA: To take final action.

DR. SANDLER: Correct.

MS. TURNER-BAILEY: Well, it is one thing, we can take a vote to vote; we have done that before.

DR. SANDLER: I think that would be calling the question.

MS. TURNER-BAILEY: It' s been moved by Dr.- by Commissioner Sandler that we vote to approve the standard with the proposed technical amendments put forth by the department.

MR COREY: Support.

MS. TURNER-BAILEY: I was just getting ready to say there is no support. It has been supported by Commissioner Corey. Any discussion? Yes, Commissioner Goldman?

MR. GOLDMAN: I appreciate all the testimony and appreciate, Jan, what you had to say. It strikes me that what we are faced with here is a very significant problem for the Certificate of Need Commission. We have had a lot of people talk about the integrity of the process. In the past the process has been, is there a need for beds. We have had some testimony about bed need but not the kind of detailed testimony we are accustomed to hearing. We have had more testimony about access. But the access was for access to patients in Detroit being continued by allowing Detroit hospitals to expand, which is sort of a competition without the argument, not a bed need methodology argument. We' ve got, as we have heard, the possibility of having new bed need methodology coming forward in the December meeting. Will that be a panacea? Probably not. Will anything be a panacea in this difficulty circumstance? Probably not.

I have heard you say, Jan, this is an apolitical solution. I understand why you say that. I think this is intensely political, however, and that the state legislature is essentially saying quid pro quo, we will get rid of C if you do something on B. That may be an apolitical solution, but it sounds kind of political to me. So I worry about what some of the speaker have worried about saying, are we politicizing the process too much. On the other hand, as Michael' s pointed out, maybe this is the way to preserve the process. Those, I think, are the problems that we have. You have got some people arguing if we pass this it is the beginning of the end of the Certificate of Need process. We' ve got other people arguing if you don' t pass this it is the beginning of the end of the Certificate of Need process.

From my perspective it is certainly a different approach than the kind of approach we have taken in the past. We are looking at three different things. We are looking at bed need methodology in Oakland County without the same kind of normal bed need methodology that we have had in the past. We are looking at monopoly arguments. You have certainly heard people in Oakland County arguing why other people shouldn't come in, and people who aren't in Oakland County arguing why they should come in. That's a monopoly argument that is part of the bed need methodology and part of the Certificate of Need. If fact, one of the things the Certificate of Need does is give some people a certificate and others not a certificate. We also have the access question which, as a speaker has brought up, is certainly part of Certificate of Need. We need to preserve access. Will this preserve access to the people in the city of Detroit? We have heard St. Johns and Henry Ford and DMC all saying that their core mission is in Detroit and they are not going to abandon Detroit. Do I personally believe that going to the suburbs will be the complete answer to their problem? I do not, you do not, they do not. They may make some money on the deal, they may open some new markets, but there is going to be a lot of other solutions that have to occur to make the market in Detroit viable. And I actually agree with the comments about Medicare and Medicaid being part of the solution to that problem, not the Certificate of Need process. So why do I say all this? Because it strikes me we have a very difficult issue in front of us. We have to decide what this language will do to the integrity of the Certificate of Need process and whether we think it will enhance it or defeat it. I don't know if any one of us are wise enough to really know the long-term consequences of what we are doing today, but it strikes me that's the issue that we have all got to consider.

MS. TURNER-BAILEY: Any further discussion?

MR. DELANEY: For the record --

MS. TURNER-BAILEY: Commissioner Delaney?

MR. DELANEY: I am concerned about the fact that I think approving this language would put the process at risk and that it will just be the issue du jour that our legislators put forth to where it will neutralize any value that the CON process has provided in the past.

MS. TURNER-BAILEY: Yes?

MS. CHRISTENSEN: I wanted to say, Ed, that political, it's apolitical from the department's point of view. I'm not saying it is apolitical from other's point of view. But the issue we are concerned about is the access to care issue. It is interesting that there is a part in the CON law that talks about financial viabilities of health systems. It has never been particularly addressed and never been a standard that I know of that's been brought to the Commission on that. But it is increasingly, in the market we see today, an issue for the State of Michigan. We have a significant number of hospitals that are on the edge. We have some very successful ones and some, mainly in our urban areas, that are not financially viable and they are handling uncompensated care in incredible amounts. The issue of whether or not this is about long-term viability of the CON program, I have a feeling that if the bed needs had been responsive, if the updates and the changes had allowed for some flexibility in the system, that we would not have had 3(b) and 3(c) put in. The fact that it is in there at all, that we have what some have termed as legislative meddling, although I would argue, with all due respect, that they are elected by the people and they do pass the law and our Governor gets to decide whether she agrees with it, but it is up to them to vote it and pass it first, so they wouldn't perceive it as meddling by any means, I'm sure.

But I think that language was in there because for a long period of time it was thought that the restriction on bed movements was becoming increasingly unrealistic for every case and under almost every circumstance. With respect to the update of the bed need methodology, it is true a lot of work has been put into the update on that and our staff has been supporting that. There is a lot of work that needs to be done yet on that. The issue of what constitutes need and how that gets defined, how many beds are needed, whether or not payer mix is part of the need or fits into that is the question. There are a series of questions that need to be answered about that.

In this particular case, these transfers were put into statute by the majority of the people in the house and the senate and were signed by the Governor into law. So in a sense they have made a determination that these needs are appropriate. And I have to tell you, from the department's perspective, we think the transfers are appropriate as well. Because we see an impending crisis in the city of Detroit of unparalleled scope and reach,

and we need every available hand, we need every available bilge pump to help bail this thing out and make it work, and this is one part of it.

MS. TURNER-BAILEY: Commissioner Hagenow?

MS. HAGENOW: I'm just sitting here thinking about how I even got here on this Commission. And that it basically was a result of things that were not the normal way of doing business. So the legislature did get involved, and I can't overlook that as the reason we are here today. If we say it should have gone the way it always has gone, you know, a lot of us wouldn't even be here. So this is different business. And I also think that the flexibility piece is something that was a big part of the why we got here is there needs to be a greater responsiveness. The market doesn't stay the same. And that weighs heavy in my mind in terms of the reason why the department has come up with this conclusion.

I also hear a lot of times that we should wait for the judicial or we should wait for the legislative, all these other bodies, and it seems to me that what you have put before us is not a win/lose but a win/win. From the constituents that is a compromise, undoubtedly, but it seems to me there is a lot of work that has gone on to reach this, and what we need to do at this point is to be responsive to that and not to hold to rigidness that got us here in the first place. Another point is that it's transfers not new beds. I think that weighs heavy in my mind in that we are letting the systems make some flexible decisions. It adds competition in certain places, and I think the monopolistic point that was made earlier is very true, and I think that allowing systems to be flexible as long as they stay within that number is not adding to that overall issue that seems to be so prominent in people's mind like there is 800 new beds. This is transferred beds.

MS. TURNER-BAILEY: Commissioner Smant?

MR. SMANT: Well, I agree with a little bit about what everyone has said, so it is kind of hard to summarize. I believe that 619 and how it structured this Commission was a good thing. I do not agree that the standards we have today was a good move on the part of the legislature. I know that we have fears on this board about what may be the repercussions if we do not pass this. My feeling there is that we are appointed by the Governor, approved by the senate, to carry out the duties and to establish policies and procedures that we feel are best for all the citizens of the state. And my way of looking at these standards, I'm concerned about the lack of need requirement in the standards. I also am concerned about the very targeted area that has been identified. And I feel that if we do take a stand, if it is not in favor of the standards, that we still have carried out our mandate as Commissioners, we have used our best judgment based on information we have received, and I would be reluctant to think that the legislature would in any way see it any other way.

MS. TURNER-BAILEY: Any other discussion? Dr. Ajluni.

DR. AJLUNI: Mr. Christensen, in keeping with what Ed Goldman spoke about with what's coming in December with the bed analysis, how realistic is it that in December we would have a meaningful assessment of the need for beds in western Oakland County?

MS. CHRISTENSEN: Well, perhaps others could speak to it, but my view is, and the department's view is that there is significant work to be done in the bed need standard yet. We are just going through some of the methodology and some of the preliminary reports from the tech committee, and I know they are still working diligently on it and doing the best that they can to make the numbers fit or to make the system work. It's not there yet. There is a considerable amount of work, from the department's point of view, that needs to be done yet.

Secondly, the bed need methodology as it is currently constructed, and largely as it is being proposed to continue by the tech committee with some minor adjustments, doesn't deal at all with the issue of access to care or payer mix. So it won't address this central core issue that the legislature wanted addressed when they passed 619. It is not on that wavelength at all. Now, could the bed need methodology with considerable discussion and debate over an extended period of time, because I know we want to be thoughtful and considerate and very careful about everything we adjust, could it consider issues like payer mix in large urban centers and the rest of it? It could, and maybe it should over time. It is not there yet, and nothing I have seen from the tech committee suggests that they are considering that at all. So it misses what I think the legislature intended with the transfers under B and C.

MS. TURNER-BAILEY: Mr. Steiger, would you mind making a comment to that?

MR. STEIGER: Sure. As I have indicated before, I think in September, we really, our progress to a large degree is a function of how much support we get from the department. We have gotten a lot of support in the last few months, and it is our expectations the 12 volunteers, the 12 or so volunteers that have devoted a lot of hours to this, and as I said, are again meeting tomorrow, it is our expectation and or feeling that we are going to keep meeting and keep working on this so that we can finish in December. And it is certainly my hope that with the continued support of the department staff we will be able to do that.

MS. TURNER-BAILEY: Thank you. I' m sorry, there is a question. Mr. Steiger, there was a question.

MR. STEIGER: I' m sorry?

MS. CHRISTENSEN: First a comment and then a question. We certainly will continue to provide all due staff that we can and support the committee. And I think we have done that and we will continue to do that because we are concerned about the bed need. And we appreciate deeply the work that the committee has done.
Could you double-check my accuracy, here, though? Does anything that the committee' s deliberated on to date deal with the issue of the payer mix in urban areas?

MR. STEIGER: Yes, it has. The bed need methodology that was formulated 20 or 25 years ago used either the statewide average or the lesser of that for the terms of the use rates. We deliberated long and hard about that about nine or ten months ago. We have decided that we are going to use the actual use rates in these areas no matter how high those use rates are. So that if an area, Saginaw Flint, whatever, has high actual inpatient use rates, we are going to use those actual use rates, and the bed need will be formulated based on that. We realize that' s not a perfect solution, but we had extensive discussion on that and we feel that that covers the arena.

MS. CHRISTENSEN: I was really asking a slightly different question, though. Has the committee considered the issue of uncompensated care, Medicaid-eligible care and other insurance care as a factor in its bed need deliberations?

MR. STEIGER: No, I' m not sure that we have. But I guess I would ask you how you would propose to do that. We certainly have been open, these have been open meetings, everyone is free to participate, make comments, so I would ask you how you would argue we would make that into the formulas.

MS. CHRISTENSEN: Well, I agree it' s a very difficult, long process to figure out what that would be, but I only point out that that was, I believe, a motivating factor when the legislature passed 3(c) and 3(b) transfers. At least that' s what they told me.

MR. STEIGER: I guess my final comment would be, take a look at what the results are, take a look at the actual occupancy rates. They better both be somewhat in line.

MR. STYKA: Just to remind the Commission, a committee is only a body that is going to make advice and recommendations to this group. And ultimately this group, through deliberations and the testimony, is how it is going to have to make its decision. I think we all understand that.

MS. TURNER-BAILEY: Right. I think we all understand --

MR. STYKA: A report coming in December doesn' t mean something magic is going to happen.

MS. TURNER-BAILEY: Right, but in my mind a report coming in December may give us some statistical or databased opportunity to make a decision; not, here is the decision.

MR. STYKA: I just wanted to make sure, because we have a lot of new members, that they understood the system.

MS. TURNER-BAILEY: Yes. This is our second sort of issue with this today, right? We are waiting for advice on another issue as well and we will then have the opportunity to act on that when the advice comes.

Commissioner Goldman?

MR. GOLDMAN: Yes, I had a quick question. In your proposed methodology so far, are you looking at current occupancy rates and projected trends for the future or just current occupancy rates? Do you understand?

MR. STEIGER: We are basing our projections based on future population projections.

MR. GOLDMAN: Future population projections. Thank you.

MS. TURNER-BAILEY: Commissioner Sandler?

DR. SANDLER: Yes. I would like to call the question.

MR. DELANEY: Support.

MS. TURNER-BAILEY: It has been moved and supported with discussion that the Commission approve the language as -- oh, okay. The motion is to approve cutting off debate. I will take a show of hands. All those in favor signify by raising your hand? Looks like nine for, two against.

MR. STYKA: Eight to two. There' s only ten people.

MS. TURNER-BAILEY: Eight to two, okay. I didn' t actually count them, I just subtracted. It is, unfortunately, I will mention that Commissioner Maitland was not able to attend today because of time and scheduling and his schedule. He indicated to me this is the first meeting he has missed the entire time he has been on the Commission, and he really regretted that he could not make it today, and we all regret his presence (inaudible). I wanted to make that comment. So now we are back to the original motion to approve the language as submitted by the department with the technical changes. Again we will vote by a show of hand. Those who vote to approve, please raise your hand. Four. Those opposed raise your hands. Six. Is that right? Okay. So this language has not been passed as put forth. We will move on to the next agenda item which is to discuss future meeting dates. The next meeting of the Certificate of Need Commission at this time is scheduled for December 9. I don' t anticipate any further special meetings in between that time. And you will see on the agenda the dates for all future meetings March, June, September and December for 2004.
I don' t have any cards for public, for the public comment section. And unless somebody jumps up quickly. Larry?

MR. HORWITZ: Could you just indicate what the vote was, because we found --

MS. TURNER-BAILEY: Six to four.

MR. HORWITZ: We thought one person abstained.

MS. TURNER-BAILEY: Six to four.

DR. SANDLER: Maitland absent.

MR. STYKA: It was six to four, Larry.

MR. HORWITZ: Can you tell us what the vote was each way? Who voted each way?

MS. TURNER-BAILEY: Any other public comment?

DR. SANDLER: Larry - Sandler, Hagenow, Goldman and Corey voted for approval. The other six voted no.

MR. HORWITZ: Thank you.

DR. SANDLER: You are welcome. Always a pleasure. I want you to know.

MS. TURNER-BAILEY: I don' t have any cards for public comment, so seeing none I will entertain a motion-Commissioner Sandler?

DR. SANDLER: Yeah. Before we adjourn I have several questions concerning the future agenda items unrelated to bed relocation. (inaudible) I would call patient care issues. Does the department believe that we can go forward with lithotripsy on the December 9th meeting?

MS. TURNER-BAILEY: On the December meeting we are going to go back to our regular work plan. We just scheduled this as a special meeting.

DR. SANDLER: I understand. Does it look like that will be done?

MS. TURNER-BAILEY: I would think so.

DR. SANDLER: Are we also going to address the possible MRI issue for rural areas which also was getting a lot of talk from people?

MS. TURNER-BAILEY: I don' t think we will be ready for that. We will take a look at where we are with each issue and put together the agenda. If you have some thoughts on that, feel free to call me.

DR. SANDLER: Thank you. Thank you, Renee. And if I don' t see anybody before, have a nice Thanksgiving.

MS. TURNER-BAILEY: Thank you very much. I will take a motion for adjournment.

DR. AJLUNI: Moved.

MR. GOLDMAN: Support.

MS. TURNER-BAILEY: Moved and supported to adjourn. All those if favor signify by saying aye. Opposed? We are adjourned.

(Deposition concluded at 12:00 noon)